It took me four or five attempts to get the tug started. I then shifted it into drive while the engine rpm still was high. I had my foot on the brake, but it took off like a race car anyway. An HH-46 helicopter sat just 10 feet in front of the tug, and we were heading right for the helicopter's main mount. I tried changing direction and pressed harder on the brake, but nothing affected the tug's heading. We ran into the landing strut and wheel assembly, canting the strut and damaging the outer rim of the wheel assembly.

We were fortunate that the damage was light, and it didn't require a mishap report. The pintle hook hit directly on the wheel assembly, preventing damage to the stub-wing.

We were just trying to get the job done, but I failed to apply the four ORM principles to minimize both risk and cost during this maintenance action:

1. Accept risks when benefits outweigh costs. The risk of driving a tug that I wasn't licensed to operate and the potential cost of the damage that could have occurred outweighed the benefit. I simply was lucky no one got hurt and the damage wasn't worse.

2. Accept no unnecessary risk. I ignored this clear rule.

3. Anticipate and manage risk by planning. I could have and should have anticipated that operating a tug near an aircraft was risky in itself. We should have managed the risk better and simply moved the NC-10C by hand, like we've done so many times before. Relying on luck isn't a part of a good plan.

4. Make risk decisions at the right level. As a CDQAR, I'm the enforcer of the NAMP in my shop and squadron, and I knew better. The NAMP, previous lessons learned through mishap reports, and stories in *Mech* repeatedly have told maintainers how to prevent Navy and Marine aviation and ground mishaps of this nature from happening. But I ignored that information.

The four ORM principles apply to being a leader of Marines and senior maintainer. A big mistake was operating a piece of support equipment for which I wasn't formally trained or licensed to operate. The biggest personal error was endangering the life and health of the Marine in the passenger seat next to me. I learned a career lesson.

SSgt. Allen is a CDQAR in the avionics shop at VMR-1.

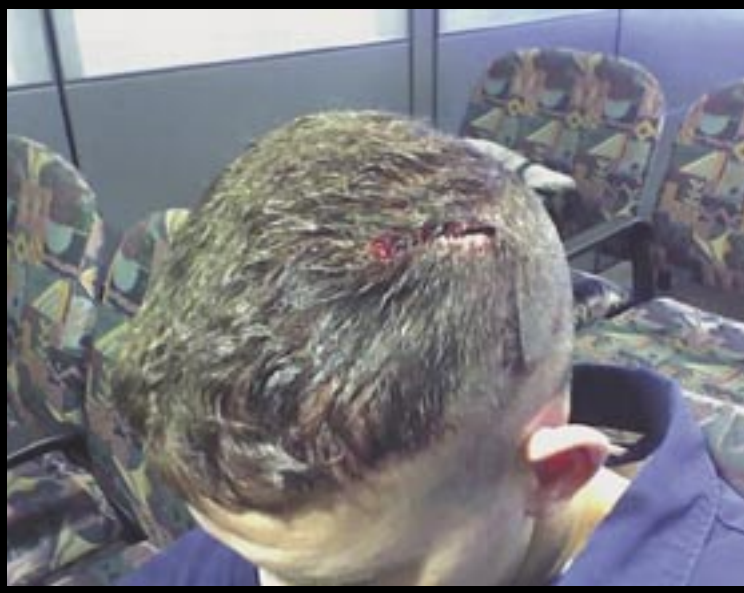
I Saw

By AT2 Joshua Skiles

One duty section weekend, I was working inside aircraft 603, looking for a wire that had been giving our avionics shop a fit for the past couple of weeks. I wanted to start from the beginning to make sure all the troubleshooting we had done wasn't lost because we had missed something simple. We almost had gutted the entire cockpit and right side of the aircraft for a modification, and it now was the perfect time to be searching for breaks in this line. But I wasn't prepared for a break of a different kind.

To start searching for the troublesome line, I told maintenance control I needed the aircraft in "no power" status because I was working inside the circuit-breaker panels. I started from the switch in the cockpit and noticed that the wire I had to chase went up and behind the overhead, center circuit-breaker panel in the cockpit. I lowered that panel and continued to follow the wire 20 feet back through the aircraft's fuselage before finding the break. Realizing I needed a flashlight to avoid fixing

the Light



the problem in the dark, I began walking back to the cockpit where I had left my tools.

I knew the overhead circuit-breaker panel was hanging down and that I had to duck. As I stepped up the stairs to the cockpit, I thought I had squatted enough to keep from hitting my head. In the dark, though, it's hard to be sure what "low enough" really is.

I walked forward and suddenly, Bang! And all I saw were white lights. I knew immediately that I had ripped a huge gash in my head. I reached up to check my head, and when I brought down my hand to look, my palm was completely red. I immediately locked my toolbox and exited the plane. By this time, blood was running down the side of my face and head. I walked into maintenance control and let the duty chief know what had happened.

After spending a couple of hours in the emergency room and having 11 staples put in my head, I took some time to look back and think about what had happened.

How could I have prevented this mishap? First, I should not have been in such a rush to do my job. I was tired of this gripe and just wanted it done. Second, I could have continued working in a central location and kept the area where I was working cleaner. Familiar advice like "don't let your guard down" and "remember this is unforgiving environment" come to mind, but the one that fits best is "complacency." As we gain experience and confidence in our rate and on our aircraft, we sometimes assume every event will occur as smoothly as previous ones. Every time you begin a job without respecting the hazards and paying attention, you roll the dice and relearn an old lesson… the hard way.

I remember my mistake every time I run my fingers across the top of my head and feel a scar that will be with me the rest of my life.

Petty Officer Skiles works in the AT shop at VAW-121.